Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: TROPHY CLUB MEDICAL CENTER 2850 S HWY 114 TROPHY CLUB TX 76262	MFDR Tracking #: M4-10-3010-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: INDEMNITY INSURANCE CO OF NORT Box #: 15	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Not paid at 200% APC Appealed 12.23.09 Lack of acknowledgement from carrier."

Amount in Dispute: $197.25

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier stands by the original and reconsidered audits. The documentation provided does not indicate any unusual expenses or circumstances that justify additional payment. Based on the following information there is no additional allowance warranted at this time."

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
08/28/2009	CPT Code 64415-59-LT	$119.22 x 200% = $238.44	$197.25	$197.25
			Total Due:	$197.25

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, effective for medical services provided in an outpatient acute care hospital on or after March 1, 2008, set out the reimbursement guidelines for hospital outpatient services.

This request for medical fee dispute resolution was received by the Division on March 2, 2010.

According to the explanation of benefits, the services in dispute were paid using a contracted fee arrangement. Tex. Lab. Code Ann. §413.011(d-3) states that the division may request copies of each contract under which fees are being paid, and goes on to state that the insurance carrier may be required to a pay fees in accordance with the division's fee guidelines if the contract is not provided in a timely manner to the division. On September 22, 2010 the division requested a copy of the contract between the network and the health care provider. The carrier failed to provide a copy of the requested documentation. For that reason, the disputed health care will be reviewed in accordance with §134.403.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
   - G, 908 – Per the CCI edits, this procedure is included in the value of a comprehensive or mutually exclusive procedure billed on the same day.
   - W1 – Workers Compensation State Fee Schedule adjustment.

- 375 – Please see special "note" below. You have requested a re-evaluation on bill F7TX 12020. Based on the following information there is no additional allowance warranted at this time. Reimbursement is persuent [sic] to §134.403 Hospital Facility Fee Guideline, Medicare CCI coding policies applied.

2. Division rule at 28 TAC §134.403(e) states, in pertinent part, that "Regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables;"
3. Pursuant to Division rule at 28 TAC §134.403(f), "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register.* The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 200 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent."
4. Under the Medicare Outpatient Prospective Payment System (OPPS), all services are classified into groups called Ambulatory Payment Classifications (APCs). Services in each APC are clinically similar and require similar resources. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Within each APC, payment for ancillary and supportive items and services is packaged into payment for the primary independent service. Packaged services are considered integral to the primary paid service and are not separately reimbursed. An OPPS payment status indicator is assigned to each HCPCS code. The status indicator for each HCPCS code is shown in OPPS Addendum B, and a full list of status indicators and their definitions is published in Addendum D1 of the OPPS proposed and final rules each year, both of which are publicly available from the Centers for Medicare and Medicaid services.
5. CPT Code 29826-LT and 29827-LT were listed on the table of disputed services; however they are not in dispute. These codes are Status T codes. Status T codes are defined as an outpatient significant procedures subject to multiple procedure discounting. The highest paying Status T APC is paid at 100%; all others are paid at 50%. The requestor has listed negative amounts of ($27.00) for CPT Code 29826-LT and ($13.46) for CPT Code 29827-LT; therefore, these codes will not be reviewed.
6. CPT Code 71020 was listed on the table of disputed services; however it is not in dispute. The requestor has listed a negative amount of ($0.37); therefore, this code will not be reviewed.
7. CPT Code 64415-59-LT is considered a Status T code and subject to the multiple procedure discounting. Also, according to the code and lay descriptions, CPT Code 64415-59-LT is an injection of anesthetic agent; brachial plexus, single. The physician anesthetizes the brachial plexus with a single injection to provide anesthesia and pain control to the arm. This code is considered a Col 2 edit to CPT Code 29826-LT; however a modifier is allowed. The requestor has attached modifier -59 and has documented the procedure in the operative report, "Adequate general anesthesia was obtained after an interscalene block has been placed" and "I had already injected the subacromial space with 0.5% Marcaine with epinephrine." Therefore, reimbursement is recommended.
8. Upon review of the documentation submitted by the Requestor and Respondent, the Division finds that:
   (1) No documentation was found to support a contractual agreement between the parties to this dispute;
   (2) MAR can be established for these services; and
   (3) Separate reimbursement for implantables was NOT requested by the requestor.

Based upon the documentation submitted by the parties and in accordance with Texas Labor Code §413.031(c), the Division concludes that the requestor is due additional payment. As a result, the amount ordered is $197.25.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.305, §133.307, §134.403
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $197.25 plus accrued interest per Division rule at 28 TAC §134.130 and §413.019 (if applicable), due within 30 days of receipt of this order.

DECISION/ORDER:

		March 14, 2011
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.